PART D PAYMENT SYSTEM

*payment***basics**

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In 2006, Medicare began a voluntary outpatient drug benefit known as Part D. A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA)–Prescription Drug plans (MA–PDs) delivers the benefit. In each of 34 geographic regions, plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies covered, pharmacy networks, and quality of services. Plans bear some risk for their enrollees' drug spending. Overall, Medicare subsidizes premiums by about 75 percent and provides additional subsidies for beneficiaries who have low levels of income and assets.[1] Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids.

The drug benefit

The standard 2011 benefit will include:

- a $310 deductible;
- coverage for 75 percent of allowable drug expenses up to a benefit limit of $2,840;
- a $4,550 catastrophic limit on true out-of-pocket spending[2] (or $6,447.50 in total drug expenses for enrollees without supplemental drug coverage); and
- about 5 percent coinsurance for drug spending above the out-of-pocket (OOP) threshold (Figure 1).

Prior to 2011, enrollees with standard benefits were responsible for paying the full cost of drug spending greater than the initial benefit limit but less than the out-of-pocket threshold. The Patient Protection and Affordable Care Act of 2010 (PPACA) directed CMS to phase out this coverage gap between 2011 and 2020. Under the standard benefit, cost-sharing for both brand and generic drugs will be reduced each year until 2020, when the coverage gap will be eliminated and beneficiaries will pay 25 percent cost sharing for all drugs until they reach the OOP threshold.

Plans can and often do offer alternative coverage structures. For example, a plan can offer a deductible lower than $310, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage.

Under Part D, Medicare provides primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals with incomes up to 100 percent of poverty have no deductibles, nominal copays, and no coverage gap. Beneficiaries who do not qualify for full Medicaid benefits but whose incomes are below 150 percent of poverty and who meet an asset test receive full or partial coverage for premiums and cost sharing and do not face a coverage gap.

Medicare's subsidy amounts

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), Medicare provides plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries.[1] That average subsidy takes two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above the out-of-pocket threshold. Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

This document does not reflect proposed legislation or regulatory actions.

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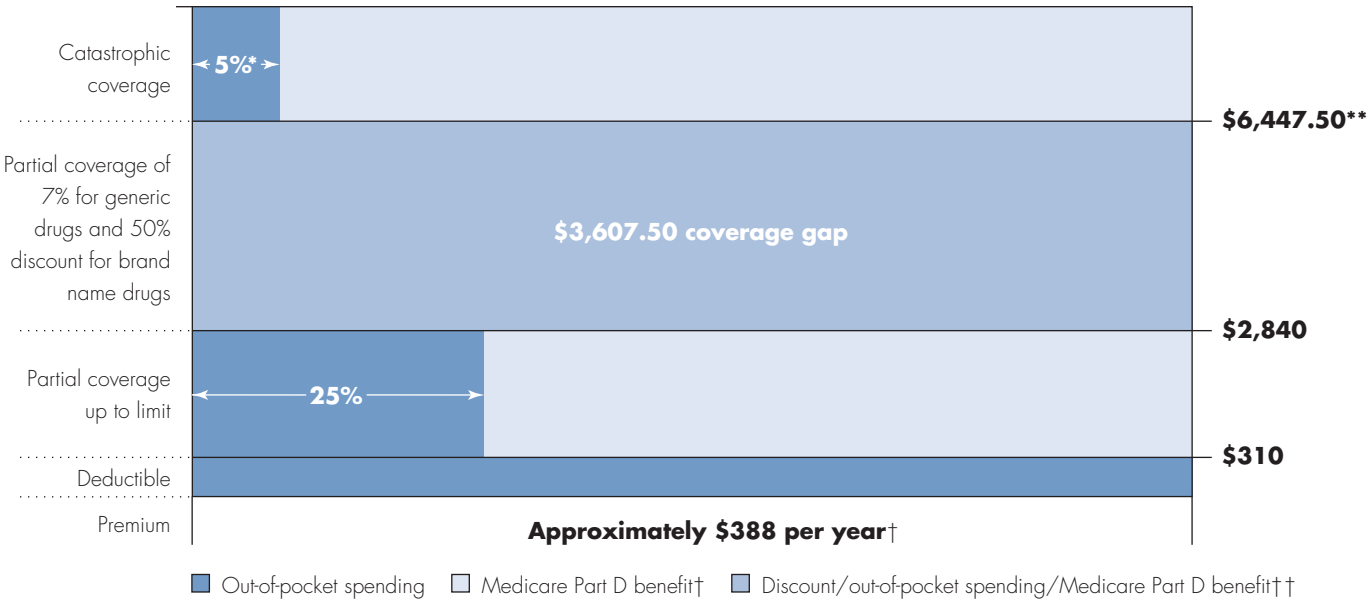
Figure 1 Standard drug benefit in 2011



Note: Benefit structure applies for an enrollee who has no supplementary drug coverage.
* Cost sharing above the out-of-pocket (OOP) threshold is the greater of either 5 percent coinsurance or a copay of $2.50 for generic drugs, or $6.30 for brand name drugs.
**Equivalent to $4,550 in OOP spending: $310 (deductible) + $632.50 (25% cost sharing on $2,530) + $3,607.50 (93% cost sharing for generic drugs, 50% cost sharing for brand name drugs, and 50% manufacturer discount for brand name drugs in the "coverage gap").
†There is a base beneficiary premium of $388 per year, which is 25.5% of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.
††Beginning in 2011, cost sharing for drugs filled during the coverage gap will be reduced to 50% for brand name drugs (the remaining 50% will be paid by pharmaceutical manufacturers), and 93% for generic drugs (the remaining 7% will be picked up by the Part D benefit).

In addition, Medicare establishes symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plans' potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). These corridors are scheduled to widen, meaning that plans should bear more insurance risk over time. Also, Medicare pays plans that enroll low-income beneficiaries most of their enrollees' cost sharing and premiums.

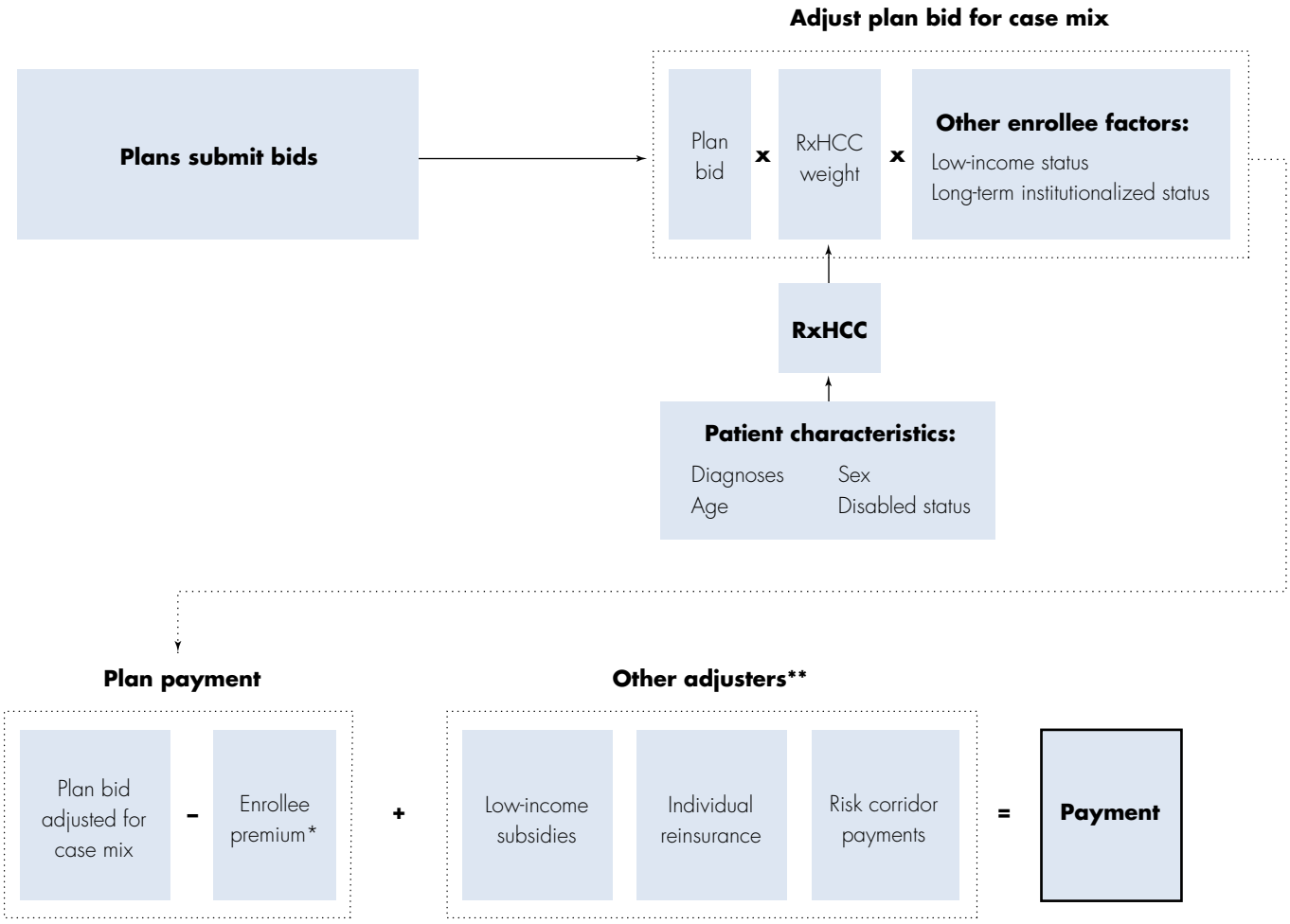
Note that although plans get essentially the same level of direct subsidy per enrollee (modified by risk adjusters), the level of subsidies granted through the other three mechanisms differ substantially from plan to plan. Subsidy dollars vary depending on the characteristics of individuals that each plan enrolls (e.g., income and health status), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

Part D replaced Medicaid as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage for their dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan submits bids annually to the Centers for Medicare & Medicaid Services (CMS) by the first Monday in June. Those bids should reflect the plan's expected benefit payments plus administrative costs after they deduct expected federal reinsurance subsidies. Plans base their bids on expected costs for a Medicare beneficiary of average health; CMS then

Figure 2 Part D payment system



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

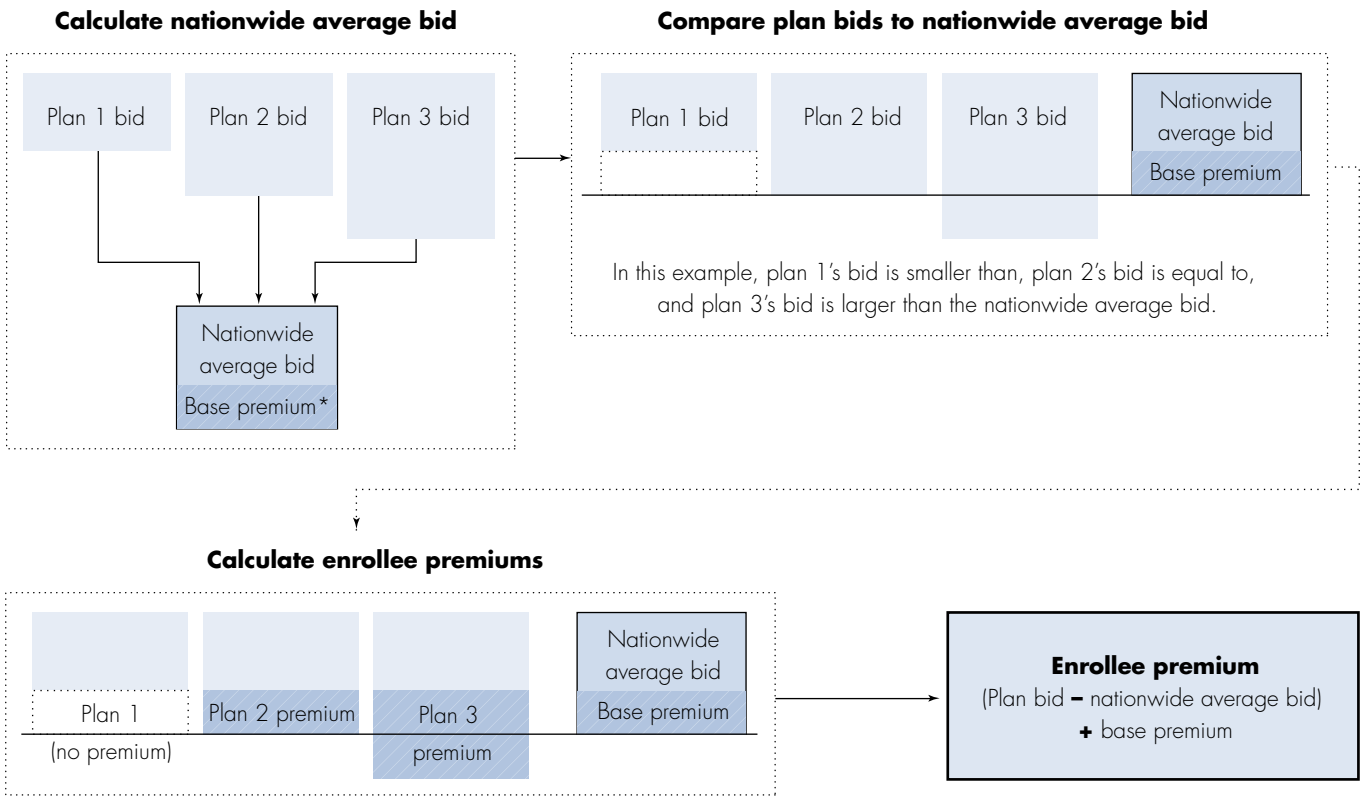
adjusts payments to plans based on the actual health status of the plans' enrollees.

CMS pays plans a monthly prospective payment for each enrollee (the direct subsidy). This payment is first adjusted by the enrollee's case mix and other subsidy factors, namely low-income status and long-term institutionalized status (Figure 2). A second adjustment to the plan's approved bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) CMS also provides plans with interim prospective payment adjustments for individual reinsurance and low-income subsidies. The agency reconciles actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.

Calculating enrollee premiums

CMS takes plans' standardized bid amounts for basic benefits or the portion of plan bids attributable to basic coverage and calculates the average (Figure 3). From this nationwide average, plan enrollees must pay a base premium plus

Figure 3 Calculating enrollee premiums



Note: *Base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5% and a denominator of 100% minus CMS's estimate of aggregate plan revenues for Part D benefits that they receive through federal individual reinsurance subsidies. Beginning in 2011, Part D will start collecting additional premiums from higher income enrollees. The extra premium amount is equal to the difference between 35, 50, 65, or 80% and the 25.5% applied to the nationwide average bid adjusted for individual reinsurance.

any difference between their plan's bid and the nationwide average bid.

Beginning in 2011, individuals with modified adjusted gross incomes exceeding $85,000 ($170,000 for couples) will be subject to a reduced premium subsidy similar to the income-related premium under Medicare Part B. The base premium amount for beneficiaries not subject to a reduced premium subsidy is $32.34 in 2011. Enrollees in costlier plans face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.[4]

Most low-income beneficiaries do not pay a premium because Medicare pays for their premium up to a regional threshold amount, calculated as an enrollment-weighted average premium for each PDP region. Since enrollees tended to select or were auto-enrolled in plans with lower premiums, using enrollment weights to calculate the regional thresholds has led to fewer premium-free plans available for low-income beneficiaries. As a result, many individuals have had to change plans or pay the portion of the premium that exceeds the regional threshold to remain in the same plan. To reduce the effects of annual changes in plans that qualify as premium-free, the PPACA changed the benchmark calculation methodology to exclude Medicare Advantage rebates.

Benefit and payment updates

Medicare updates the deductible, benefit limit, and catastrophic threshold amounts in the standard Part D benefit each year. Plan payments are a function of plans' updated bids. The benefit's threshold amounts increase by CMS's estimate of the annual change in drug spending per person. ■

1 Beginning 2011, the premium subsidy will be reduced for certain higher income beneficiaries as a result of changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA). For more information, refer to the section on calculating enrollee premiums.

2 The term "true out of pocket" refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Specifically, only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own out-of-pocket (OOP) spending; that of a family member or official charity; supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies; and, under CMS's demonstration authority, supplemental drug coverage paid for with MA rebate dollars. In addition, beginning in 2011, drug spending made on behalf of the beneficiary by AIDS Drug Assistance Program, the Indian Health Service, and the 50 percent discount paid for by pharmaceutical manufactures for brand name drugs will count toward the OOP threshold. Beneficiaries need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their OOP spending toward the $4,550 limit.

3 The PPACA eliminates the coverage gap by: 1) requiring pharmaceutical manufacturers to offer a 50 percent discount on brand name drugs filled during the coverage gap, 2) gradually phasing down cost sharing for generic drugs beginning in 2011, 3) phasing down cost sharing for brand-name drugs beginning in 2013, and 4) reducing the OOP threshold on true out-of-pocket spending over the 2014 to 2019 period.

4 Beneficiaries (other than those who receive low-income subsidies) who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late enrollment penalty similar to that for Part B. Creditable coverage refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.